2021 Group MedicareBlue Rx Participant Enrollment Form

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-838-3827** (TTY: **711**).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-877-838-3827** (TTY: **711**).

Group MedicareBlue Rx complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Group MedicareBlue℠ Rx (PDP) is a Medicare-approved Part D sponsor. Enrollment in Group MedicareBlue Rx depends on renewal of the plan sponsor's contract with Medicare. Coverage is available to members of an employer or union group and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa,* Blue Cross and Blue Shield of Minnesota,* Blue Cross and Blue Shield of Montana,* Blue Cross and Blue Shield of Nebraska,* Blue Cross Blue Shield of North Dakota,* Wellmark Blue Cross and Blue Shield of South Dakota,* and Blue Cross Blue Shield of Wyoming.*

*Independent licensees of the Blue Cross and Blue Shield Association

Group MedicareBlue℠ Rx (PDP)
A Medicare Prescription Drug Plan

S5743_072320GNN07_C

OMB No. 0938-1378
Expires: 7/31/2023

Group MedicareBlue Rx Participant Enrollment Form

To enroll in Group MedicareBlue Rx, please provide the following information and this enrollment form to your employer group or other designated contact.

A. Personal information (please print clearly)

Group name: State of Iowa	$5/$10/20%/45%/33%	Group number: 38073IOWA	**Requested effective date:**
Last name:	First name:	Middle initial:	❑ Mr. ❑ Mrs. ❑ Ms.
Email address (optional):			
Birth date: M M D D Y Y Y Y	❑ Male ❑ Female	Home phone number: ( ) –	Alternate phone number (optional): ( ) –

Permanent residence street address
(Don't enter a P.O. Box):

City State ZIP code

Mailing address, if different from your permanent address
(P.O. Box allowed):

City State ZIP code

B. Please provide your Medicare insurance information

Medicare number: ☐☐☐☐–☐☐☐–☐☐☐☐

Is entitled to: Effective date (MMDDYYYY):

HOSPITAL (Part A) ☐☐☐☐☐☐☐☐

MEDICAL (Part B) ☐☐☐☐☐☐☐☐

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Enrollee name: _____

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C. Please answer the following questions to help Medicare coordinate your benefits

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs.

Will you have other **prescription** drug coverage in addition to Group MedicareBlue Rx (PDP)?

❑ Yes ❑ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.

Name of other coverage:	Member number for this coverage:	Group number for this coverage
_____	_____	_____

D. Enrollment authorization: By completing this enrollment application, I agree to the following:

IMPORTANT: Read and sign below

- I must keep Part A or Part B to stay in Group MedicareBlue Rx.
- By joining this Medicare prescription drug plan, I acknowledge that Group MedicareBlue Rx will share my information with Medicare, who may use it to track my enrollment, to make payments and other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement on page 5).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:

1) This person is authorized under state law to complete this enrollment, and

2) Documentation of this authority is available upon request by Medicare.

Signature: _____ **Today's date:** _____

If you are the **authorized representative,** you **MUST** sign above and provide the following information:

Name (Print): _____ Phone number: (_____)_____

Address: _____ City: _____ State: _____ ZIP code: _____

Relationship to enrollee: _____

❑ I want all mail for this member sent to me.

Completing this field is optional

Select one if you want us to send you information in an accessible format.

❑ Braille ❑ Large print ❑ Audio CD

Please contact Group MedicareBlue Rx at **1-877-838-3827** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., daily, Central and Mountain times. TTY users can call **711**.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.